Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-11-4162-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: HOUSTON ISD Box #: 21	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting resolution to the Memorial Herman hospital portion of the bill remaining outstanding. I was admitted from the emergency room at the time of admission Texas Dept. of Insurance information was not at hand to present to the hospital business office and my group information was used. Attached you will find a copy from Aetna what was paid to Memorial Herman. The coverage of my flex account covers me only. After the $995.67 + $25.90 was used from my account funds were deleted, I am requesting refund to me in the amount of $995.67 + $25.90 and the balance paid to Memorial Herman."

Amount in Dispute: $1,510.87

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As you can see from the information attached to this response, the Carrier has reimbursed the claimant for the $1,021.57 paid out of pocket and the provider the MAR amount of $1,076.95. With the payment being made as indicated, all issues in this matter should not be resolved."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, LC, 912 S. Capital of Texas Hwy., Ste. 300, Austin, TX 78746

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
02/01/11 – 02/28/11	Out of pocket expenses	$995.67 + $25.90	$1,021.57	$0.00
01/31/11 – 05/09/11	Lost time from work	52.5 hrs x $9.32/hr	$489.30	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - EOBS were not submitted by either party.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Tex. Admin.

Code §133.307?

2. Is time lost from work reviewed under Medical Fee Dispute Resolution?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the DWC-60 Table of Disputed Services the injured employee is seeking reimbursement for out-of-pocket expenses for her workers' compensation injury in the amount of $1,021.57.
2. The injured worker is also seeking reimbursement for time lost at work in the amount of $489.30. According to Tex. Admin. Code §133.305(a)(3) Medical dispute resolution is a process for resolution of a medical fee dispute. A medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. Time lost at work is not considered a health care treatment or service. Therefore, Medical Fee Dispute Resolution does not have the authority to review the costs associated with time lost from work.
3. The insurance carriers' representative responded to the dispute and submitted proof that the carrier has reimbursed the claimant $1,021.57 paid out-of-pocket with check number 10077151261 dated August 11, 2011. Pursuant to §133.307(e)(3)(A) the Division has determined that a medical fee dispute no longer exists.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.